DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 00-15

2. STATE: Kansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.120

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ -0-
b. FFY 2001 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A
#12.a., Page 3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A
#12.a., Page 3

10. SUBJECT OF AMENDMENT:
Prescribed Drug Limitations

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Janet Schalansky is the Governor's designee

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Janet Schalansky

13. TYPED NAME:
Janet Schalansky

14. TITLE:
Secretary

15. DATE SUBMITTED:
09/01/00

16. RETURN TO:
Janet Schalansky
KS Dept of Social & Rehabilitation Services
DSOB, 6th Floor
915 SW Harrison
Topeka, KS 66612

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
09/05/00

18. DATE APPROVED:
NOV 9 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 1 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid and State Operations

23. REMARKS:

cc:
Schalansky
Day
Bieberly

SPA CONTROL

Date Submitted 09/01/00
Date Received 09/05/00

FORM HCFA-179 (07-92)

Instructions on Back

Substitute per letter dated 11/08/00 w

KANSAS MEDICAID STATE PLAN

Prescribed Drugs Limitations

Prescribed medications are limited to those prescription-only and over-the-counter drugs, supplies and devices selected for inclusion on the Medicaid formulary.

Selected specific drug entities or products within specific therapeutic categories shall be covered services only with prior authorization. These are detailed in the provider manual.

The maximum quantity of medication which can be dispensed for any prescription is a 34 day supply.

Pharmacy services for parenteral administration of total nutritional replacements and intravenous medications in the consumer's home are not covered through the pharmacy program and must be billed through the Home Health Services/Durable Medical Equipment program.

Pharmacy services related solely to non-covered transplant procedures are non-covered.

NOV 3 2000